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ABSTRACT

Competition for mental health funding among advocates for treatment, prevention, and research often produces more tension than productivity. Competition is fueled by dependency on varied streams of funding and lack of coherent connections and coordination among the host of public and private agents involved in addressing child and adolescent mental health. By not adequately financing intervention to address the mental and psychosocial concerns related to the zero through 18 population, policymakers do more than ignore the well being of the nation's youth. From the standpoint of children and adolescents, one of the most significant policy trends over the last decade involves tying significant portions of public financing to schools in order to address youth's mental health. Efforts to develop a comprehensive, multifaceted, and integrated approach will have to purse many avenues. Suggestions for ways to enhance mental health program funding for young people and for improving programs include: (1) reforms that enable redeployment of existing funds away from redundant or ineffective programs; (2) reforms that allow flexible use of categorical funds; (3) new initiatives stemming from tobacco settlement revenues; and (4) develop mechanisms to enhance resources through use of personnel in training, work study, and service programs. (Contains 13 Web sites and 17 references.) (JDM)

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Mental Health in Schools Center
Training and Technical Assistance

A Center Brief and Fact Sheet . . .

Financing Mental Health for Children & Adolescents

November, 2000

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Center Brief . . .

Financing Mental Health for Children & Adolescents

ADEQUATE FINANCING OF MENTAL HEALTH IS ESSENTIAL TO THE FUTURES OF CHILDREN AND THE ECONOMY

As the Surgeon General's recent mental health (MH) report notes: "State and local government has been the major payer for public mental health services historically and remains so today."[1]

Although small in relation to state and local funding, over the last 35 years, the federal government has added resources to help finance the cost of MH programs. Examples include funding for Medicaid and special programs for those with serious mental illness and emotional disability, such as the Community Mental Health Block Grant, the PATH program for the homeless with mental illness, Community Support programs, the Comprehensive Community MH Services for Children and Their Families Program, the Knowledge Development and Application Program, and a variety of training and research initiatives.

However, data on financing for MH are difficult to amass, especially with respect to children from zero through eighteen. Difficulty arises from many factors. First, a problem exists with how MH is defined. Quite often, in discussing MH legislation, policy makers focus solely on persons who are diagnosed as mentally ill or emotionally disturbed. In other cases, the focus is on a specific problem, such as school violence, substance abuse, or other psycho-social problems that fall into the realm of MH concerns. Relatively few programs are funded to promote positive MH, resiliency, and general wellness, such as MH education and programs to foster social and emotional development.

Other difficulties in tracking finances arise because of variations in where the money comes from and where it goes. Some funds come from federal taxes. A small proportion of these dollars are used to support initiatives at the national level; the rest of the funding is given to the states for Medicaid, block grants, and categorical programs.

States use federal dollars along with state allocated funds for state department programs and related expenses and funnel the rest along with state allocations to local communities and schools. Similarly, local legislative bodies allocate some funds to address MH and psychosocial concerns in schools and communities.

In addition to public dollars, insurance companies, managed care companies, charitable groups, and foundations, underwrite services. Schools and public-private agencies also may develop contractual relationships that result in a back and forth flow of reimbursement dollars for services and administrative costs.

Beyond community and school programs and related administrative costs, financing is provided for training, research, evaluation, and other projects and initiatives. And, those who can afford it may purchase desired services.

With these difficulties in mind, it should be clear why the perspective on expenditures offered next only highlights a few facets of the big picture.

How Much is Expended?

Most information on MH expenditures focuses only on direct treatment of mental disorders, substance abuse, and dementias (e.g., Alzheimer's disease). Adult and child data are not separated. As summarized in the 1999 Surgeon General's report on MH:

- total expenditures in 1996 were above $99 billion – about 7 percent of total U.S. health spending estimated at $943 billion a percentage decline over the decade
- more than two-thirds ($69 of the $99 billion) was consumed by MH services, with outpatient prescription drugs among the fastest-rising expenses (accounting for about 9 percent of total direct costs)
- treatment of substance abuse was almost $13 billion (about 1 percent of total health spending)
- public sector per capita costs for treating the 5.1 million individuals with serious mental illness (about 1.9 percent of the population) is estimated at $2,430 per year, leaving about $40 per year for persons without insurance and with problems not seen as severe

Who paid? Approximately $37 billion (53 percent) for MH treatment came from public payers. Of the remaining $32 billion, $18 billion came from private insurance. Most of the rest was direct payment – including copayments related to private insurance, prescription costs not covered by Medicare, supplementary insurance, as well as direct payment by the uninsured or insured who chose not to use their insurance coverage for MH care.

Another perspective is provided by what is spent in schools. The following data are especially relevant given that a recent National Institute of Mental Health (NIMH) multisite survey of children and adolescents (ages 9 to 17 years) indicates that school systems probably are the largest provider of MH services to youngsters.[2] Figures related to special education well-illustrate the problem of collating information on expenditures for child and adolescent mental health.

- Federal government figures indicate 5.2 million are spent on special education. Overall costs are about $43 billion (and rising), with the federal government funding only about 5.3 billion. Estimates in many school districts indicate that about 20% of the budget can be consumed by special education. How much is used directly for efforts to address MH concerns is unknown, but given that over 50 percent of those in special education are diagnosed as learning disabled and over 8 percent are labeled emotionally/behaviorally disturbed, much of the budget may underwrite MH related activity.[3]
- Looking at total education budgets, one group of investigators report that nationally 6.7 percent of school spending (about 16 billion dollars) is used for student support services, such as counseling, psychological services, speech therapy, health services, and diagnostic and related special services for students with disabilities. Again, the amount specifically devoted to MH is unclear, and the figures do not include costs related to time spent on such matters by other school staff, such as teachers and administrators. Also not included are expenditures related to special initiatives such as safe and drug free schools programs and special arrangements such as alternative and continuation schools and funding for special school-based health, family, and parent centers. For example, a recent report from the Robert Wood Johnson Foundation indicates that 34 states are using federal/state block grant funds, general funds, or a combination of both to provide some support for school-based health centers. How many dollars are provided is unclear as is the percentage going for MH concerns.[4]

Despite limited data, studies indicate: (1) The public sector provides the greatest proportion of financing of MH services. (2) Problems of access and equity arise because of a lack of parity in insurance coverage. (3) The vast proportion of public and private funding for MH is directed mainly at severe, pervasive, and/or chronic psychosocial problems. For example, in the last decades of the 20th century, support for services at severe, pervasive, and/or chronic psychosocial problems. For example, in the last decades of the 20th century, support for services came mainly from legislation designed for children and youth diagnosed as having emotional and behavioral "disabilities" and "mental illnesses" or to address problems such as violence and substance abuse.[5] On a lesser scale, legislation provided for the economically disadvantaged to access early and periodic MH assessment and treatment. (4) Medicaid funding has expanded over the last 20 years and the Medicaid program's design has profoundly reshaped delivery of MH care and has devolved administrative responsibility for MH services to local authorities, such as county MH systems.[6] (5) In the private sector, insurance and the introduction of managed care are also reshaping the field, with an emphasis on cost containment, benefit limits, and expanded coverage for prescription drugs.

Finally, it is noteworthy that the competition for MH funding between advocates for treatment, prevention, and research often produces more tension than productivity. The competition is fueled by dependency on varied streams of funding and the lack of coherent connections and coordination among the host of public and private agents involved in

addressing child and adolescent MH, such as pediatricians, primary care providers, and those concerned with education, social welfare, and criminal justice.

Present Financial Policy

At national, state, and local levels, basic financing questions remain unanswered: What are the overall expenditures (differentiating public and private dollars)? What are the specific sources of funding? What is the cost-effectiveness of various interventions? What are the data for different groups?

To put data on current expenditures in proper perspective, better information is needed on:

- What is being done? (e.g., What interventions are offered? By whom and where? How comprehensive, multifaceted, and integrated are programs/services?)
- Who and how many are reached? (e.g., How many in the zero through eighteen age group are served? What is the SES, racial, and ethnic composition at each age level?
- What are the positive results? (e.g., What is the nature, scope, validity, and impact of the interventions?)
- What are the negative results? (e.g., What impact do current funding patterns have on matters such as misdiagnosis and misprescription and the increasing and probable overreliance on medication?)

The answers to such questions will provide a stronger basis for policy decisions on the amount and nature of finances.[7]

Extrapolating from available data. The following are some reasonable policy conclusions about current status and future needs based on available studies:

- The public sector (particularly state and local government) is responsible for the greatest proportion of financing of MH services.
- The vast proportion of public and private funding for MH is directed at severe, pervasive, and/or chronic psychosocial problems. For those in crisis and those with severe impairments, current financing is only sufficient to provide access to a modicum of treatment, and even this financing is not accomplished without creating major inequities of opportunity. Few programs and services are available for children and youth, and those that are available too often are inadequate in nature, scope, duration, intensity, quality, and impact.[8,9]
- Expansion of Medicaid funding for MH care has reduced direct state funding and profoundly reshaped delivery of care.
- In the private sector, insurance and the introduction of managed care are reshaping the field, with an emphasis on cost containment and benefit limits and with expanded coverage for prescription drugs.
- There is a trend toward tying significant portions of public financing for MH and psychosocial concerns to schools and a related trend toward encouraging school and community collaborations.
- Future funding for MH and psychosocial concerns needs to be less marginalized in policy and practice, less categorical in law and related regulations, less fragmented in planning and implementation, and more equitable with respect to access and insurance coverage.

An area where policy makers have made a major shift in thinking involves funding for demonstration projects. Examples of such projects are seen in school-linked services initiatives, such as New Jersey's Youth Services model, Missouri's Caring Communities, California's Healthy Start. On the federal level, agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Health Resources Service Administration (HRSA) support project's related to systems of care, school-based health centers, MH in schools, state infrastructure demonstrations for coordinated school health, and safe and drug free school projects. It has become clear that much of this activity focuses only on a small proportion of the population, and support for large-scale replication or even for sustaining the demonstation is difficult to generate. Thus, funders are moving away from a "project" mentality.

From the standpoint of children and adolescents, one of the most significant policy trends over the last few decades involves tying significant portions of public financing to address MH and psychosocial concerns to schools. One result is that schools have increased the nature and scope of some of their pupil personnel services. In addition, schools are experimenting with a variety of ways to enhance school-based and school-linked services by drawing on different funding sources. For example, School-Based MH Programs in 64 Baltimore City Public Schools are supported by pooling school and community agency resources. The school system provides over one and a half million dollars to community-based MH programs that provide MH services to students in regular education in 54 schools. Medicaid funds are used to support the program. In many of the 54 schools and for 10 additional

ones, state and federal MH dollars allocated through the Baltimore Mental Health System, Inc. provide over a million dollars to supplement the school system's funding. The district bills Maryland Medicaid on a fee for service basis for most health care providers -- speech pathologists, school psychologists, social workers, nurses, psychiatrists, physical therapists, and occupational therapists. This includes a small recovery for MH services unrelated to special education.

Funding sources. In addition to general agency and school funding, programs to address child and youth MH related concerns increasingly are seeking access to a variety of funding sources including:

- Medicaid and Supplemental EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
- Maternal and Child Health (Title V) block grants
- ESEA (Elementary and Secondary Education Act) Title I and Title XI
- IDEA (Individuals with Disabilities Education Act)
- Community MH Services block grant
- Programs from the several agencies concerned with promoting health, reducing violence and substance abuse, and preventing pregnancy, dropouts, and HIV/AIDS
- Titles IV-B, IV-E, and XX of the Social Security Act
- After school programs
- Job programs
- State-funded initiatives for school-linked services
- As feasible, private insurance reimbursements and private fee for services
- Prekindergarten, there are major efforts to ensure that the EPSDT program fulfills its MH mandate. This trend supports the renewed interest in refocusing Head Start on its original commitment to MH.

(See appended sources for internet access to funding information.)

All this is consistent with the nation's goals of ensuring every child enters school ready to learn and attends schools that are safe. It all also underscores the need for comprehensive and multifaceted approaches that are sustainable and replicable on a large scale.

Emerging Trends

For communities and schools, the range of MH and psychosocial concerns confronting young people requires the provision of programs that go beyond services for children with mental disorders. The activity must encompass a multifaceted continuum of programs and services including those designed to:

- Promote healthy social and emotional development (assets) and prevent problems (by fostering protective factors and resiliency and addressing barriers to development and learning)
- Early intervention after onset
- Provide specialized assistance for persons with severe, pervasive, and/or chronic problems.

Establishing the full continuum and doing so in an integrated and systematic manner requires weaving community and school resources together. While few communities and schools have enough resources, most have facets of such a continuum in place. Ironically, for instance, schools serving large numbers of students who are economically disadvantaged often have special funding that embellishes general fund support for services. Similarly, neighborhoods housing such schools usually are the recipients of a range of publicly financed health and human service programs.[10] But, the problems of intervention marginalization, fragmentation, redundancy, major gaps, and inequities prevail and have major implications for funding policy.

Opportunities to improve financing practices. As the new millennium begins, there are increasing pressures and opportunities to do more about MH. This is reflected in the 1999 Surgeon General's report on mental health, as well as in the growing sense of concern about the health of young people, policies stressing parity in funding for physical and mental health, and initiatives to include special education students in regular classrooms. There also are increasing pressures and opportunities stemming from the need to address the problems of sustainability and large-scale replication -- including the extra costs of initial implementation of major changes.

Obviously, a major concern among policy makers is to ensure that already allocated funds are used in ways that get the most out each dollar. "Getting the most" is not just a matter of cost-efficiency, but is concerned with cost-effectiveness over the long-run. In this respect, various strategies have been outlined. These include:

- *Redeploying resources* by
  >enhancing efficiency to maximize resource use
  >shifting funding from higher to lower-cost programs and services to increase the system's ability to meet the needs of the many
- *Leveraging* (public and private, dollars and non-monetary resources) by using what is available to qualify for other resources -- both new and matching funds

- *Refinancing* – a specialized form of leveraging that substitutes federal and state entitlement funding (which is open-ended) and related administrative claiming to free up local funds to serve other youngsters and their families (Examples of federal entitlement programs are among the funding sources previously cited.)

- *Pooling* – combining some funds from several agencies and programs to enhance collaboration for a shared goal (as occurs with block funding); at a less ambitious level, several funding streams might be *coordinated* to support coordinated/integrated intervention activity; at the most ambitious level, budgets for overlapping roles and functions would be *blended*

- *Reinvesting savings* resulting from policies that ensure funds accrued from effective financial strategizing are kept to further a program vision

- *Amortizing costs* with one-time funding or over a long period

- Minimizing reliance on *pernicious funding*, such as project funding that distracts from expeditiously moving forward a program vision or that sets in motion activity that is not sustainable when the project ends (This is an instance of applying a central financing principle that stresses funding should not drive programs, rather the program vision should drive financing.)

- Using effective *brokers* to facilitate the focus on financing.

Opportunities to enhance funding

No single source of or approach to financing is sufficient to underwrite major systemic changes.[11] Thus, efforts to develop comprehensive, multifaceted, integrated approaches will have to pursue many avenues. Emerging opportunities to enhance MH program funding for young people and for sustaining and improving such programs include:

- Reforms that enable redeployment of existing funds away from redundant and/or ineffective programs

- Reforms that allow flexible use of categorical funds (e.g., waivers, pooling of funds)

- Health and human service reforms (e.g., related to Medicaid, TANF, S-CHIP) that open the door to leveraging new sources of funding for mental health

- New initiatives stemming from tobacco settlement revenues

- Pursuing collaborations that combine resources in ways that enhance efficiency without a loss (and possibly with an increase) in effectiveness (e.g., interagency collaboration, public-private partnerships, blended funding)

- Policies that allow for capturing and reinvesting funds saved through programs that appropriately reduce costs (e.g., as the result of fewer referrals for costly services)

- Targeting gaps and leveraging collaboration (perhaps using a broker) to increase extramural support while avoiding pernicious funding

- Developing mechanisms to enhance resources through use of personnel in training, work-study and service programs, and volunteers (including professionals offering pro bono assistance).[12]

With respect to initial implementation of major changes and large-scale replication, concepts such as start-up costs, "glue money," and underwriting for replication are receiving greater attention. Financing for "getting from here to there" at one demonstration site or at many sites includes the extra costs for staffing the infrastructure for change. These include costs related to change agent staff, building motivational readiness, providing ongoing incentives for change, establishing problem solving mechanisms, and restructuring the operational and program infrastructure -- including upgrading facilities and information systems, retraining staff, and installing new intervention approaches. In this context, glue money is described as the "cement" used to pull and hold programs, services, and personnel together during the initial stages of planning and implementing systemic changes.

Ultimately, the trend is toward finding ways to weave school and community resources together in a seamless manner. This ideal, of course represents a fundamental transformation and "reculturing" of prevailing infrastructure mechanisms and operational systems. Movement in this direction is reflected in current reform efforts to restructure systems and redeploy resources.

Conclusion

By not adequately financing interventions to address the MH and psychosocial concerns related to the zero through eighteen population, policy makers do more than ignore the well-being of the nation's youth. They ignore the indirect costs to society in terms of eventual lost productivity and increased demands on the justice and welfare systems. With respect to mental illness alone, such costs, at last estimate in 1990, represented nearly a $79 billion loss for the economy.[13] Thus, if not just because it is in the best interests of children, at least because it is in the best interests of the economy, it is time to increase the investment in promoting the MH of young people – both by fostering healthy development and addressing problems.

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Endnotes

1. U.S. Dept. of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Author.
2. A study by Shaffer, et al (1996) as cited in the Surgeon General's report on Mental Health.
3. U.S. Dept. of Education (1999). *To assure the free appropriate public education of all children with disabilities: Twenty-first annual report to Congress on the implementation of the Individuals with Disabilities Education Act*. Washington, DC: Author.
4. Dryfoos, J. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families*. San Francisco, CA: Jossey-Bass, Inc.
5. For example, see the 1997 reauthorization of the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the various federal initiatives related to making schools and communities safe and drug free.
6. U.S. Dept. of Health and Human Services (1997). *Medicaid and school health*. Baltimore, MD: Author.
7. NIMH took a small step toward addressing this financing data vacuum by issuing an RFP in 1999 entitled "Cost Survey of Mental Health Treatment for Children." The discussion of the problem in that document outlines many of the problems associated with studying cost and financing issues related to child mental health services (see RFP NO. NIMH-99- DS-0004).
8. Adelman, H., & Taylor, L. (1999). Mental Health in schools and system restructuring. *Clinical Psychology Review, 19*, 137-163.
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12. Fisher, H. with Cohen, C. & Flynn, M. (2000). *Federal funding for early childhood supports and services: Sources and strategies*. Washington, DC: The Finance Project; Giffin, M., Rosenblatt, A., Mills, N., & Friedman, M. (1998). *Capturing cash for kids: A workbook for reinvesting in community based prevention approaches for children and families*. Sacramento, CA: The Comprehensive Integrated Services Reinvestment Project of the Foundation Consortium; Friedman, M. (2000). *Reforming finance for family and children's services*. Sacramento, CA: Foundation Consortium.
13. Rice, D.P., & Miller, L.S. (1996). The economic burden of schizophrenia: Conceptual and methodological issues and cost estimates. In M. Moscarelli, A. Rupp, & N. Sartorious (Eds.), *Handbook of mental health economics and health policy. Vol. 1: Schizophrenia* (pp. 321-324). New York: Wiley & Sons.

For More Information

The Internet provides ready access to info on funding and financing.

Regarding funding, see:

>*School Health Program Finance Project Database* – http://www2.cdc.gov/nccdphp/shpfp/index.asp
>*School Health Finance Project of the National Conference of State Legislators* – http://ncsl.org/programs/health/pp/schlfund.htm
>*Snapshot from SAMHSA* – http://www.samhsa.gov
>*The Catalog of Federal Domestic Assistance* – www.gsa.gov/
>*The Federal Register* – www.access.gpo.gov/GPOAccess/
>*GrantsWeb* – http://www.research.sunysb.edu/research/kirby.html
>*The Foundation Center* – http://fdncenter.org
>*Surfin' for Funds* – guide to internet financing info http://smhp.psych.ucla.edu/ (search *Quick Find*)

Regarding financing issues and strategies, see:

>*The Finance Project* – http://www.financeproject.org
>*Center for the Study of Social Policy* – http://www.cssp.org
>*Center on Budget and Policy Priorities* –http.www.cbpp.org
>*Fiscal Policy Studies Institute* –www.resultsaccountability.com
>*Making the Grade* – http://www.gwu.edu/~mtg/sbhcs/financing.htm

A Few Additional References (not included in the endnotes)

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Watson, S., & Westheimer, M. (2000). *Financing family resource centers: A guide to sources and strategies*. Washington, DC: The Finance Project.

FACT SHEET: *Financing Mental Health for Children & Adolescents*

Data on financing for mental health (MH) services and programs are difficult to amass. The difficulty arises from many factors. For one, the figures depend on whether the focus is on mental illness, psychosocial problems, and/or the promotion of general wellness. Other difficulties stems from variations in funding sources (e.g., public- private, national, state, or local levels), to whom the funds go (e.g., agencies, schools, or community based organizations), and for what purposes they are used (e.g., direct, administrative, and evaluative costs related to programs, services, initiatives, projects, training, research).

Data

Most information on MH expenditures focuses only on direct treatment of mental disorders, substance abuse, and dementias (e.g., Alzheimer's disease). Adult and child data are not separated. As summarized in the 1999 Surgeon General's report on MH:

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Another Perspective Is Provided By What Is Spent in Schools

- Federal government figures indicate 5.2 million are spent on special education. Overall costs are about $43 billion (and rising), with the federal government funding only about 5.3 billion. Estimates in many school districts indicate that about 20% of the budget can be consumed by special education. How much is used directly for efforts to address MH concerns is unknown, but given that over 50 percent of those in special education are diagnosed as learning disabled and over 8 percent are labeled emotionally/behaviorally disturbed, much of the budget may underwrite MH related activity.

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FINANCING POLICY

The following are some conclusions about current status and future needs based on available studies:

- The public sector (particularly state and local government) is responsible for the greatest proportion of financing of MH services.
- The vast proportion of public and private funding for MH is directed at severe, pervasive, and/or chronic psychosocial problems. For those in crisis and those with severe impairments, current financing is only sufficient to provide access to a modicum of treatment, and even this is not accomplished without creating major inequities of opportunity. Few programs and services are available for children and youth, and those that are available too often are inadequate in nature, scope, duration, intensity, quality, and impact.
- Expansion of Medicaid funding for MH care has reduced direct state funding and profoundly reshaped delivery of care.
- In the private sector, insurance and the introduction of managed care are reshaping the field, with an emphasis on cost containment and benefit limits and with expanded coverage for prescription drugs.
- There is a trend toward tying significant portions of public financing for MH and psychosocial concerns to schools and a related trend toward encouraging school and community collaborations.
- Future funding for MH and psychosocial concerns needs to be less marginalized in policy and practice, less categorical in law and related regulations, less fragmented in planning and implementation, and more equitable with respect to access and to insurance coverage.

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The emerging program vision. A central financing principle is that funding should not drive programs, rather the program vision should drive financing. For communities and schools, the range of MH and psychosocial concerns confronting young people require a vision that encompasses much more than providing services for those with mental disorders. The activity must entail a multifaceted continuum of programs and services including those designed to:

- promote healthy social and emotional development (assets) and prevent problems (by fostering protective factors and resiliency and addressing barriers to development and learning)
- intervene as early after the onset of a problem as is feasible, and
- provide specialized assistance for persons with severe, pervasive, and/or chronic problems.

Establishing the full continuum and doing so in an integrated, systematic manner requires weaving community and school resources together and requires financing for start-up costs and underwriting for ensuring that programs and services are available and accessible to all who can benefit.

Funding sources. Another basic funding principle is that no single source of or approach to financing is sufficient to underwrite major systemic changes. Thus, in addition to general agency and school funding, programs to address youngsters' MH related concerns increasingly are seeking access to many funding sources including:

- Medicaid and Supplemental EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
- Maternal and Child Health (Title V) block grants
- ESEA (Elementary and Secondary Education Act) Title I and Title XI
- IDEA (Individuals with Disabilities Education Act)
- Community MH Services block grant
- programs from the several agencies concerned with promoting health, reducing violence and substance abuse, and preventing pregnancy, dropouts, and HIV/AIDS
- Titles IV-B, IV-E, and XX of the Social Security Act
- after school programs and job programs
- state-funded initiatives for school-linked services
- and, as feasible, private insurance reimbursements and private fee for services.

Opportunities to Enhance Funding

- reforms that enable redeployment of existing funds away from redundant and/or ineffective programs
- reforms that allow flexible use of categorical funds (e.g., waivers, pooling of funds)
- health and human service reforms (e.g., related to Medicaid, TANF, S-CHIP) that open the door to leveraging new sources of MH funding
- accessing tobacco settlement revenue initiatives
- collaborating to combine resources in ways that enhance efficiency without a loss (and possibly with an increase) in effectiveness (e.g., interagency collaboration, public-private partnerships, blended funding)
- policies that allow for capturing and reinvesting funds saved through programs that appropriately reduce costs (e.g., as the result of fewer referrals for costly services)
- targeting gaps and leveraging collaboration (perhaps using a broker) to increase extramural support while avoiding pernicious funding
- developing mechanisms to enhance resources through use of trainees, work-study programs, and volunteers (including professionals offering pro bono assistance).

For More Information

The Internet provides ready access to info on funding and financing.

Regarding funding, see:

>*School Health Program Finance Project Database* – http://www2.cdc.gov/nccdphp/shpfp/index.asp

>*School Health Finance Project of the National Conference of State Legislators* – http://ncsl.org/programs/health/pp/schlfund.htm

>*Snapshot from SAMHSA* – http://www.samhsa.gov

>*The Catalog of Federal Domestic Assistance* – www.gsa.gov/

>*The Federal Register* – www.access.gpo.gov/GPOAccess

>*GrantsWeb* – http://www.research.sunysb.edu/research/kirby.html

>*The Foundation Center* – http://fdncenter.org

>*Surfin' for Funds* – guide to internet financing info http://smhp.psych.ucla.edu/ (search *Quick Find*)

Regarding financing issues and strategies, see:

>*The Finance Project* – http://www.financeproject.org

>*Center for Study of Social Policy* – http://www.cssp.org

>*Center on Budget and Policy Priorities* – http:www.cbpp.org

>*Fiscal Policy Studies Institute* – www.resultsaccountability.com

>*Making the Grade* – http://www.gwu.edu/~mtg/sbhcs/financing.htm

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